DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/16/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G107	A. BUILDING _____ B. WING _____	11/02/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLISTIC 06	7129 7TH STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from October 31, 2007 through November 2, 2007. A random sample of three clients was selected from a client population of six male clients with varying degrees of disabilities. The findings of this survey were based on observations at the group home and three day program, interview with day program staff and residential direct care staff and management, and a review of the habilitation and administrative records to include the review of unusual incident reporting system.	W 000		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure of each client, parent, or legally authorized party of the client's medical conditions, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment for one of the three clients in the sample. (Client #1) The finding includes: The facility failed to ensure Clients #1 and his	W 124		

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2007 NOV 27 P 3:03

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ilana Thomas — TITLE: President — (X5) DATE: 11-27-07

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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W 124	Continued From page 1 representative was informed of the risks and benefits of his behavior management plans as evidenced below: Observations of the evening medication pass on 10/31/07 at 6:15 PM revealed that Client #1 received Seroquel 300mg, Buspirone 10 mg and Clonazepam 1 mg. Interview with the Trained Medication Employee (TME), Qualified Mental Retardation Professional (QMRP) and the review of the client's Physician's orders dated 10/31/07 at approximately 7:15 PM revealed the aforementioned medication were used in conjunction with the Behavior Management Plan (BMP) to manage the client's maladaptive behaviors. Additional interview conducted with the QMRP on 8/23/07 at 11:00 AM failed to evidence that written consent for the use of the prescribed behavior support plan had not been obtained. The review of the psychological assessment dated 6/28/07 revealed that Client #1 is not able to give informed consent and/or make independent decisions on her on behalf regarding her habilitation planning, placements, treatment, financial and medical matters.	W 124	**W 124** **Client #1's guardian has been requested to provide consent for the implementation of the Behavior Management Plan.** **12/15/07**	
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.	W 148		

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W 148	Continued From page 2 This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide evidence of prompt notification of parents or guardians of a significant incident which was potentially harmful for each client residing in the facility. The finding includes: The facility failed to ensure that each client's family had been notified of unusual incidents: Review of the GHMRP incident reports and investigations on November 1, 2007, at 12:00 PM, failed to show evidence that Resident #2's family and/or guardian was notified immediately of the June 15, 2007 incident at the group home. The incident report descibed Resident #2 was observed by the overnight staff to sustained an injury to his left forearm. According to the incident report the Resident was taken to the local emergency room for evaluation and treatment.	W 148	**W 148** **Staff have been in-serviced on incident management policies and procedures. Please find evidence herewith. The emphasis of the in-service was, who to notify of an incident. The Incident Management Coordinator will on a semi-annual basis train staff on the above-mentioned subject.** **11/26/07**	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to adequately monitor, integrate and coordinate each client's active treatment. The findings include:	W 159		

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W 159	Continued From page 3 1. The QMRP failed to ensure that the Client #2 alternative active treatment schedule was implemented as written. (See W120) 2. The QMRP failed to ensure that the Client #1 guardian informed of his restrictive intervention use for his maladaptive behaviors. (See W124) 3. The QMRP failed to ensure that direct care staff implemented an alternaitve program schedule for Client #2 who was temporarily not attending his regular day treatment program. The facility's failed to ensure that client #2 was provided alternative active treatment programming while not attending his regular day treatment program. Observation on October 31, 2007 revealed that Client's #2 was not attending his day treatment program. During the day program visit on November 1, 2007 at approximately 11:00 AM, interview with the day program case manager and review of client program plan confirmed that Client #2's had not been in attending his day program plan. Interview with the day prgam staff identified that the client had not been at the program since October 24, 2007. Further interview with the day program case manager indicated that the home had not informed the program as to why Client #2 was not attending the day program. Interview with the house manager revealed that the client was not feeling well. Further interview revealed that the primary care physician recommended that the client remained at the group home until he was feeling better.	W 159	**W 159, 1** **In the future, the QMRP will ensure that staff adhere to the activity schedule and active treatment implemented as specified. Staff have been in-serviced on timely implementation of active treatment.** **W 159, 2** **Cross Reference W124.** **W 159, 3** **Cross Reference W124.** **12/15/07**	

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W 159	Continued From page 4 According to the house manager the client was scheduled to see the physician on Monday November 4, 2007 in order to cleared him to return to the day program. Interview with the Qualified Mental Retardation Professional (QMRP) revealed the the day program sent Client #2 home from the program and stated that he was not feeling well. At the time of the interview he was unsure of the actual date in which this had occurred. According to the QMRP the day program was aware as to why Client #2 was not attending their day program. Review of the program records failed to evidence any documented evidence to verify the QMRP's comments. Although the QMRp informed the surveyor that the day treatment program was made aware, there was no evidence that the facility's QMRP communicated with the day program about the client's medical leave.	W 159	**W 159** **A residential-day program communication form has been put in place. This will be used to facilitate communication between the home and the day program. The QMRP will ensure that the form is used efficiently.** **11/26/07**	
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employees to perform his or her duties effectively, efficiently and competently. The finding includes: The facility's TME failed to properly secure	W 189	**W 189** **The TME in question has been in-serviced on consistent and proper securing of medications. Training will be conducted quarterly to ensure compliance.** **11/26/07**	

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W 189	Continued From page 5 medications. (See W382)	W 189		
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation, the facility failed to keep all drugs locked securely when not being prepared for administration. The findings include: The Trained Medication Employee failed to secure medication consistently and properly as required by the agency's medication administration policy and procedures. On October 31, 2007, at approximately 6:15 PM, the Trained Medication Employee (TME) was observed to place 3 of Client #5's medication bubble packs on the counter. The TME then left the area to wash her hands in another room, leaving the packs of medications unsecured. At 6:30 PM the TME was observed again to leave medication bubble packets (seven packages belonging of Client #1's) on the counter to wash her hand in another room. The medication cabinet was again left unlock.	W 382	W382 Cross Reference W 189 11/26/07	
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel.	W 440		

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W 440	Continued From page 6 This STANDARD is not met as evidenced by: Based on review of fire drill records, the facility failed to hold evacuation drills at least quarterly for each shift. The finding includes: Interview with the House Manager on October 12, 2007, at approximately 10:55 PM and review of the fire drill log revealed that the facility failed to hold fire evacuation drills for all shifts at least quarterly. The facility failed to conduct fire drills during the following period: 11:00 AM - 7:00 AM Monday through Sunday for the period of July 2007 to September 2007 The above finding was referred to the Office of the Fire Marshall.	W 440	**W 440** **Staff have been in-serviced on consistent conduction of fire drills and proper documentation.** **A Quality Assurance (QA) person has been specifically charged with monitoring the conduction and documentation of fire drills. Monitoring will be conducted monthly to ensure compliance.** **11/26/07**	
W 454	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a sanitary environment to avoid sources and transmission of infection. The finding include: Observation on October 31, 2007 at approximately 7:05 PM the direct staff was observed to take dirty dishes out of the kitchen sink. She was then observed to stack the dishes in the utility tub in the laundry room next to the washing machine.	W 454		

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W 454	Continued From page 7 Client #5 was observed to notice the dishes in the utility tub and began to wash them. This same staff person grabbed Client #5 arm and the client stopped washing the dishes. The direct care staff washed the the remaining dishes in the utility tub. She was observed to place the washed dished on the top of the washing machine. Interview with the QMRP revealed that the agency policy instruct the direct care staff to rinse the dishes and place them in the dish washer in order to properly sanitize the dishes after each use. Interview with the house manager revealed that there had been problems with the drainage in the kitchen sink but she was not sure who had instructed the direct care to wash the dishes in the laundry room utility tub. Note: It should be further noted that the TME washed her hands in the utility tub several times during the medication administration.	W 454	**W454** **Staff have been in-serviced on infection control. The House Manager will, on a daily basis (5 days per week) monitor and supervise staff on issues pertaining to infection control.** **11/26/07**	

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I 000	INITIAL COMMENTS A licensure survey was conducted from October 31, 2007 through November 2, 2007. A random sample of three clients was selected from a client population of six male clients with varying degrees of disabilities. The findings of this survey were based on observations at the group home and three day program, interview with day program staff and residential direct care staff and management, and a review of the habilitation and administrative records to include the review of unusual incident reporting system.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observations, the GHMRP failed to maintain a safe,clean,orderly, attractive facility free from dirt and rubbish. The finding includes: During the environmental inspection conducted on November 2, 2007, the GHMRP failed to ensure the following: Internal 1. The light switch cover was exposing sharp edges and the plaster around the light switch cover was exposing some wiring and was not	I 090	**Internal** **I 090, 1** **The switch has been replaced and the hole around the light switch cover has been sealed completely. 11/ 22/07** **I 090, 2** **The cylinder of the back porch screen door will be replaced. 12/15/07** **I 090, 3** **The protective cover has been aligned. 11/22/07** **Note: An environmental audit (internal and external audit) will be conducted monthly to ensure compliance.**	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dana Thomas TITLE: President (X6) DATE: 11-27-2

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I 090	Continued From page 1 properly maintained. 2. The back porch screen door was missing the cylinder used for safe retraction of the door. 3. The heater protective cover in the upstairs bathroom was bend outward exposing a sharpen edge and could be a potential safety hazard. External 1. The QMRP office window screen was missing. 2. The window facing the stairwell leading to the second level was observed open and without a window screen. 3. The window in Client #1's walk in closet adjacent to his bedroom had a broken out window pane which exposed his personal clothing to the outside weather elements. Additionally, the window screen was missing.	I 090	**External** **I 090, 1** **The QMRP's office window does not need a screen because the window is made of transparent flexi glass that seals the entire area of the window thereby preventing foreign objects from entering the office.** **11/ 22/07** **I 090, 2** **Window screen to the stairwell will be fixed.** **12/15/07** **I 090, 3** **The window has been fixed.** **11/22/07**	
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Based on observation and interview the GHMRP failed to lock caustic agents being stored. The finding includes: During the environmental walk-through on November 2, 2007 1:30 PM revealed the following;	I 095		

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I 095	Continued From page 2 Caustic agents (e.g. liquid dish detergent) were observed being stored underneath the kitchen sink and on the kitchen counter unlocked when not being used.	I 095	**I 095, Staff have been in-serviced on infection control and safety. The House Manager will, on a daily basis (5 days a week) monitor and supervise staff on infection control and safety measures.** **11/26/07**	
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to ensure that each shift conducted a fire drill 4 times a year. The finding includes: See Federal Deficiency Report Citation W440	I 135	**I 135 Cross Reference W 440** **11/26/07**	
I 165	3507.4(c) POLICIES AND PROCEDURES The manual shall incorporate policies and procedures for at least the following: (c) Health and safety, which covers fire safety and evacuation, infection control, medication, and procedures for emergency and the death of a resident; This Statute is not met as evidenced by: Based on observation and interview the GHMRP staff failed to implement the agency's policy on infection control. The finding includes:	I 165	**I 165 Cross Reference W454 11/26/07**	

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I 165	Continued From page 3 See Federal Deficiency Report Citation W454	I 165		
I 374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident ' s guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident ' s status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident. This Statute is not met as evidenced by: Based on interview and record verification, the GHMRP failed to notify parents or guardians of significant incidents for one of the three residents in the sample. (Residents #2) The finding includes: Review of the GHMRP incident reports and investigations on November 1, 2007, at 12:00 PM, failed to show evidence that Resident #2's family and/or guardian was notified immediately of the June 15, 2007 incident at the group home. The incident report descibed Resident #2 was observed by the overnight staff to sustained an injury to his left forearm. According to the incident report the Resident was taken to the local emergency room for evaluation and treatment.	I 374	I 374 Cross Reference W 148 11/26/07	